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Infosys response to State of Illinois

The Affordable Care Act Request for Comment

Submitted to:

Governor's Health Care Reform Implementation Council - State of Illinois,
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1. Overview

Infosys Technologies Ltd is pleased to respond to the request for comments by State of Illinois. Our response is based on our extensive experience in healthcare industry and recent research conducted on Health Insurance Exchanges.

Infosys has set up a core group, completely focused on assessing and analyzing the impact of the health benefit exchanges on the Healthcare industry, potential pitfalls associated with them, potential implementation scenarios, and the role a consulting partner can play in ideating, strategizing, and automating the exchange initiatives for individual states. This approach has helped us and the industry tremendously in the past for initiatives such as 5010 and ICD10 conversions and HIPAA AS.

This document provides the details of our response to questions in the RFC document.

2. Infosys Response to Questions

2.1 Functions of a Health Benefit Exchange

Question#1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

State will be interested in health insurance exchanges because it offers a platform that allows individuals and small firms to access coverage that is portable, choice-based, and tax-advantaged. The broader goals of an exchange and hence state will be to organize the health insurance marketplace, drive system affordability, and improve the quality of the health care delivery system. But establishing health insurance exchanges will be a Herculean effort.

The Affordable Care Act requires every state to have an exchange up and running by January 1, 2014. Following are the advantages and disadvantages if state opts to setup its own exchange

Advantages to establishing a state exchange:

- If the exchange is designed by state then State has the flexibility to apply the state laws to the exchange and control over the rules of small and nongroup markets participation.
- State is better positioned to coordinate benefits and eligibility across state programs
- If the Exchange is setup by state itself then it will focus on Illinois priorities and goals
- Powerful state tool to help advance other health care priorities
- State is better positioned to coordinate benefits and eligibility across state programs
- More efficient for state agencies to coordinate with each other than to separately coordinate with a federal or regional exchange
- Prevent risk selection issues caused by varying rating/underwriting rules inside/outside the exchange
- Maximizes legislative and operative oversight
- Federal exchange will mostly be uniform across all the states, if the separate exchange is setup by the State then cultural and geographic diversity can be appropriately addressed.
- State is better positioned to coordinate benefits and eligibility across state programs
- federal government funds for planning and implementation of state exchange
- Design of federal exchange is not known.
- Powerful state tool to help advance other health care priorities

Disadvantages to establishing a state exchange:

- The major risk is Exchange should be self-sustaining by 2015 to mitigate the risk. State should look into the option of having a tool or consortium which will provide various functionalities, facilitate exchange operations and provides a no-cost model to state.
- Even if a state decides to utilize the federal exchange in lieu of its own, the state will still need to undertake efforts to ensure coordination across state entities stabilize markets, and minimize adverse selection.
- Cost for state to develop. It is not clear if federal funding will cover all costs and implementation will involve considerable state time and personnel.
- Challenges of creating new institutions
- May not realize economies of scale that could potentially be realized through a regional *or national* Exchange
- Resource intensive for state to administer (time and personnel)
- Challenges of creating new institutions

The fifth-most populous state of United States of America, Illinois is very unique state. With 11.30% poverty ratio and significant contributions to the state's economy by small employer we recommend having state exchange. State should also look for consortium to provide a no-cost model to state.

Question#2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

There are many desirable outcomes which are expected from an Exchange like: regulating healthcare cost, making sure target population receives health coverage, subsidies for eligible population etc. Few most important outcomes which will decide the fate of exchange are

- **Creation of one stop shop experience for consumers**
    - State should try and create a one-stop shopping experience for all the state consumers.
    - State can achieve this by integrating various aspect of insurance plan shopping like
        - Best suit plan recommendation engines along with various rating based on consumer feedback and other industry bodies
        - Billing and other financial services
        - Subsidy eligibility determination and calculator
        - Tax credit eligibility determination and calculator
        - Wellness and Preventive care tools

- To achieve the above mentioned functionalities state should try to explore various options like tools available in market and/or formation of consortium.

- **Promoting and achieve transparency and accountability**:
  - Achieving transparency will be critical in a competitive market like exchange where consumers will be provided with choices. Transparency of information in the exchange is necessary to
  - Gain consumer, insurer and stakeholder confidence
  - Encouraging participation of larger audience in exchange
  - Compliance to various mandates, subsidies and tax provisions as per federal and state ruling
  - To accomplish this
  - Exchange needs to make disclosure of verifiable data relate to various aspect of exchange like marketing, enrollment practices, and data sources for income and health information.
  - Exchange must also provide more and better information about health insurance plan than what is available at consumer level today.
  - Closely coordinated effort with various state and federal departments to help make exchange compliant with various state and federal rules.
  - Exchange will require detailed reporting and disclosure of administrative costs. Transparency can help state to reinforce competitive pressure to hold down administrative costs.

- **Achieving Managed Competition through exchange :**
  - The goal of a health insurance exchange should be to shift health insurance market from competition based on risk to competition based on price.
  - Exchange should provide a level playing field for all the participating health plans. This can be achieved by keeping the market rules same both inside and outside the market.
  - Exchange should provide an option to compare and make a rational choice of health plan for participant members. This can be achieved by setting up user friendly portal, multi lingual 24*7 toll free numbers and easy comparison criteria for various plans.

- **Guarantee Issue of Insurance :**
  - Exchange should make sure that coverage for individual is not rescind
  - Individual's eligibility for various subsidies and state/federal programs is effectively tracked.
  - For this to achieve state exchange should have very efficient and effective eligibility tracking system.
  - Also Exchange will have to improve its co-ordination with state agencies and federal bodies.

Question#3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

The health insurance exchanges place numerous new responsibilities and requirements on state governments to build virtual marketplaces so businesses and individuals can shop for, compare and enroll in affordable health insurance plans.

Under the ACA, exchange functions extends from offering qualified health plans to providing a range of information on those plans, to getting people subsidies for which they are eligible, to providing exemptions from the requirement to have coverage to those qualifying.

We believe apart from these basic functionalities Exchange should take on additional functions. Taking additional function would mean taking advantage of the opportunity to strengthen Illinois health care delivery system

We suggest that Exchange should have the following functions.

- Exchange should be a True one-stop-Shop with clinical and financial data integration and dash boarding
- Integration with public CDR to combine the benefits of both clinical and financial exchanges
- Exchange should have Built-in Clinical Decision Support System to allow member population to make the correct decision about their benefit requirements w.r.t. their clinical status it will also help in reducing adverse selection
- Provide an administrative mechanism for member enrollment and regulatory compliance
- Exchange should provide flexibility in vvariety of ways for members to pick and choose the best-fit plan, such as auctions, reverse auctions, callbacks etc.
- Exchange should allow one-stop management for tax deferred accounts
- Exchange should allow the member direct enrollment
- Various tools like subsidy calculators, tax calculators, online billing services etc. should be available with exchange to facilitate the use.
- Customized enrollment option for small group, exchange should also allow handheld devices support.

Along with providing additional functions State should also consider really low-cost, low-risk model for exchange. State of Illinois can consider forming controlled consortium of vendors to keep the operating cost low and administrative functioning streamlined. State of Illinois can think of including partner from various sectors like Clinical data repository, Agencies or research departments which provide risk adjustment services, Actuarial Bodies.

Question#4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

The Affordable Care Act does not require states to use a selective contracting or negotiation process to choose or limit which plans can participate in the exchange. However, such a process could help ensure that all plans in the exchange are of high quality and value to consumers.

ACA requires that exchange plans offer essential benefits and divides health plans into the four tiers. This apparently was intended to structure choice with a focus on price and value. However, ACA places no restrictions of the offer of benefits beyond the essential benefits. This means that, without further structuring by the state, there still could be a very large, perhaps unmanageable, number of plans. The state needs to decide whether to limit the menu of plan designs. It is a balance between consumer clarity versus consumer choice.

There is considerable evidence that consumers neither want nor need unlimited choice in health insurance offerings. Consumers can be overwhelmed by too much choice, particularly when making complex, high-stakes decisions like buying health insurance. A consumer faced with a dozen different silver plans offered by a dozen different insurers might well find it very difficult to identify the most appropriate, highest-value plan. Research shows that increasing options beyond a manageable level may increase consumer inertia or reliance on friends or relatives for advice and impede a rational search strategy. Price disparity in Medicare prescription drug plans, where consumers face an overwhelming variety of choices, also indicates that increasing choice among plans does not facilitate price competition. There is, moreover, evidence that older or less healthy plan members are less likely to switch plans than younger or healthier members; so increasing plan choice may encourage adverse selection.

As mentioned above state should limit the plans offer. We are also recommending exchange should have a comparison engine which compare plans on a value index which will be driven not only by price but also the benefits offered by the product. This will assist consumers to decide which plan will cover their needs and encourage more participation in Exchange.

2.2 Structure and Governance

Question#1. If the Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

Governance formation is the first and most critical strategic step in Health Insurance exchange formation. The decision of governance formation depends on the objectives of the exchange towards

- Commercial vs. non-for-profit transactions
- Administration and operational processes of exchange
- Regulatory compliance management and
- Exchange execution strategy for covering individual and small business groups

Based on these factors it is evident that the exchange needs to be governed by an advisory board or committee with representatives from different types of entities right than just Illinois state government or a single entity. For being successful exchange needs to look at not only the structure of the exchange but also different business strategies around health plan selections, negotiations as well as capturing the market base and hence it needs to involve commerce expertise as well. Also for health plans to participate they need to be relieved off the political issues involved and hence the authorities need to include semi-government as well as non-government entities. At the same time legal influence is needed to control the outside exchange market and hence government entity should also be there. In brief the advisory board should involve representatives from following types of entities

- Illinois State Government Agencies – such as Department of Health and Human Services and Department of Insurance (to control the exchange and determine the legal mandates around benefits and plans), Technology, legal agencies, treasurer's office, chamber of commerce, reinsurance body etc
- Federal Government Agencies – To review and approve the exchange policies defined by the state
- State Medicare and Medicaid Leadership – For Medicare and Medicaid eligibility management
- Private Health Plan Advisory Bodies
- Actuarial experts – For plan verifications and benefits modeling
- Agencies or research departments which provide risk adjustment services
- Disease advocacy groups, Healthcare and care management providers and Public Health
- Consumer advocacy private groups

Private entities who can manage operational and administrative activities of exchange can work under the control of the board.

Question#2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

The exchange will have to serve a broad spectrum of the population, including those with different income levels, reading levels, English-proficiency levels, and internet-skill levels. The ACA provides states with latitude in establishing a governance structure for their Exchange.

State establishes a governing body/ advisory board for governance and admiration of exchange.

- A state's secretary of health and human services or commissioner of insurance, for example, might be responsible for oversight and management of the Exchange.
- Advisory board will provide inputs on exchange policies and procedures. Board should represent broad perspective of exchange users and purchasers with an emphasis on individuals and small business who have expertise or insurance and exchange knowledge.
- Since Exchange will need to be in-sync with other state agencies like state's insurance regulator and its Medicaid agency, the Exchange governing board should include state officials with expertise in those areas.
- Health plans (public and private) and providers need a significant role in the governance of the exchange whether it be serving on the board (appointment similar to the WSHIP appointment process) or through a well-structured and legislated technical advisory committee)
- An Exchange governing board might also benefit from the inclusion of an individual with commercial health insurance experience, as well as a consumer representative
- The individual and small group markets operate under different rules than the large group market. Experts in the individual and/or small group markets have the insight into those markets and firsthand knowledge of the types of plans consumers have selected in the past and the way those markets operate. An Exchange governing board might also benefit from the inclusion of an expert from these areas.
- A balance will need to be struck between the policy-setting responsibilities of the board and the administrative responsibilities of the Exchange staff.

Utah and Massachusetts states have already implemented the health insurance exchange, before implanting governance and administration structure state can look into these models for reference.

2.3 The External Market and Addressing Adverse Selection

Question#1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

The success of the Exchange depends on strong enrollment and take-up. And to achieve self-sustaining exchange promoting enrollment in the Exchange should be state priority.

State of Illinois can consider dual market in case of small groups since small businesses work closely with agents and brokers to secure insurance. So interaction between these two independent markets will be is crucial to achieve uninterrupted coverage for small business employees. Federal health care reform specifies the following rules to protect against selection issues in a dual market:

- Plans sold inside and outside the Exchange must be in the same risk pool
- Plans sold inside and outside the Exchange must have the same premium rate
- Plans sold inside and outside the Exchange must meet the same minimum benefits standards
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre-existing conditions, medical status, or claims history
- How premiums vary based on age, geographic location, and smoking status must apply to plans inside and outside the Exchange

State should consider following 2 scenarios in case of individual market:

- Assuming Exchange can be the sole market for individuals; external market would be folded into the Exchange and all health insurance plans would have to be sold through the Exchange for individuals. In such a case exchange will not have to worry about participation of target population but this may give rise to eligibility compliance issue in case of individual mandate and subsidies. This will put added stress on the eligibility determination team of Health Benefit Exchange development.
- Both markets exist. This might discourage insurers from participating in Exchange because of the constrains like
    - Offering the same plans in the external market as they do inside the Exchange.
    - offer plans at each of the four tiers of coverage
    - Design and bargain for high-quality, low-premium plans in the Exchange

To conclude; in case of individual market state needs to come up with a combination of above two scenarios that makes the Exchange the market for most insurance but allows insurance to be sold in the external market help preserve insurers interest. Along with this to improve healthcare cost and coverage state should explore best fit plan recommendation engine based on clinical data.

Question#2. What other mechanisms to mitigate "adverse selection" (*i.e.* requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

States should eliminate counterproductive health care mandates and craft reforms that promote market choice and competition, which will help to control the cost of providing coverage. Some of the important considerations which can be implemented by the state in order to mitigate "adverse selection" are:

- One important factor is that the federal premium tax credits to help low- and moderate-income people buy insurance can be used only within an exchange. This will help ensure that the exchange is an attractive place to buy coverage — and not just for people who are more likely to have high health costs.
- Once exchanges are up and running, the tax credit now available to certain small businesses to help them defray the cost of contributing to their workers' premiums will be available only if they provide coverage to their workers through the exchanges. This, too, will likely help attract a more typical risk pool to the exchange.
- The law also requires use of a risk-adjustment system, in which plans with sicker-than-average overall enrollments receive payments to compensate them for their resulting higher costs. The payments would come from plans that enroll healthier-than-average people that do not cost as much to cover.
- Merge the Individual and Small-Group Markets over Time- Another potentially helpful provision of the Affordable Care Act requires a "single risk pool," meaning that each insurer operating inside and outside of an exchange will be required to treat all of its enrollees as a single group when setting premiums.
- Insurers within an exchange, on the other hand, will be required to offer more comprehensive Silver and Gold plans, which are more likely to attract people with significant health care needs.
- Ensure that the Risk-Adjustment and Risk-Pooling Mechanisms Work Effectively-It will also be important for states to ensure that insurers do not pay insurance-broker commissions in ways that provide incentives for brokers to steer healthier, lower-cost enrollees into plans offered outside the exchanges, such as by furnishing higher fees or bonuses to brokers who direct healthy individuals in that way.

Other than the above mentioned considerations, some other important considerations to be implemented are:

- "Prohibit insurers that participate in the exchange from establishing separate affiliates to sell only outside the exchange.
- Prohibit insurers from selling only bronze or catastrophic coverage outside the exchange; or prohibit insurers from using marketing practices or benefit structures intended to attract healthy applicants to plans outside the exchange while discouraging unhealthy applicants.
- In addition, "insurance regulators can monitor grandfathered plans carefully to make sure that they are not 'lemon dropping'--that is, encouraging high-cost enrollees to move to the exchange."

- State should focus on improving the delivery system, not on selecting risks and this should be done by diagnosis-based risk adjustment of premiums and, possibly, pooling of risks for very costly cases. Without such adjustment, it would not be possible to mitigate the effect of adverse selection.

Question#3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

Two models which can be considered in order to make a hybrid model, which will have the combined features of both, are

- Utah Health Insurance Exchange Model :

According to the Utah Health Exchange website, the Exchange "will connect consumers to information they need to make an informed choice, and in many cases, allow them to execute that choice electronically." The main characteristics of the Utah Health Exchange are to provide consumers with:

  - Helpful information about their health care and financing of that care
  - A convenient way to compare and choose a health insurance policy that meets their families' need
  - A standardized electronic application and enrollment process
  - Higher costs or premiums compared to outside exchange costs
  - Improper consumer relationship management with lengthy online and paper-based processes for consumers.

- Massachusetts Health Insurance Model:
  - Massachusetts provided individual insurance for entire population while having employers also provide coverage to their employees and overall the exchange covers more than 300000+ lives.
  - The state allowed purchase of insurance from outside exchange as well which was potentially major risk for exchange failure.
  - The initial issues were again majorly around designing plan coverage as well as technical implementations and customer relationship management.
  - Apart from this the other major challenge was around exchange governance itself. The exchange also saw a lot of resistance from brokers.

Considering both these models and their provisions for states, the state of Illinois Health Insurance Exchange model will have certain characteristics for the benefit of the Illinoisans e.g.

- Provides one-stop insurance shopping for individuals and small businesses:
- Offers enrollees a selection of "Exchange qualified" plans that meet minimum standards for coverage and affordability;

- Creates administrative mechanism for enrollment;
- Standardizes presentation of insurance options for plan comparability; provides a "rating" system for plans and significant transparency provisions;

  Redefines small businesses as 1-100 employees; states may limit to 50 until 2016.
- All plans sold in the Exchange must be certified by the Department as meeting minimum federal benefit standards:
- Four options of benefit plans: bronze (least generous), silver, gold, platinum (most generous);
- Catastrophic plans available to individuals under age 30 or those exempt from insurance requirement;
- Insurers must offer children-only plans, and may offer stand-alone dental plans.
- Exchange must contract with "navigators" to assist consumers.
- Exchange must provide a seamless application and enrollment process for individuals who qualify for subsidies, requiring coordination for enrollment in public programs if eligible.
- Federal funding: HHS will distribute implementation grants to states within one year after date of enactment of legislation.
- STATE ACTION: The Department will continue to work with HHS and other public and private stakeholders on establishing a health insurance exchange in Illinois. The Department is leading NAIC's efforts regarding Exchange development and implementation.

States are required to established transitional reinsurance for the small group and individual markets to help stabilize premiums during first three years of Exchange when risk of adverse selection is greatest

Question#4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

If the exchange and the external market operate in parallel, following considerations should be implemented without exception. If this does not happen, as discussed in the "mitigation of adverse selection" will lead to the high risk increased load of sick pool in the exchange and finally will lead to the ill functioning of the state exchange. These considerations are:

- Plans sold inside and outside the Exchange must be in the same risk pool
- Plans sold inside and outside the Exchange must have the same premium rate
- Plans sold inside and outside the Exchange must meet the same minimum benefits standards
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre-existing conditions, medical status, or claims history

- How premiums vary based on age, geographic location, and smoking status must apply to plans inside and outside the Exchange
- Offering the same plans in the external market as they do inside the Exchange.
- offer plans at each of the four tiers of coverage
- Design and bargain for high-quality, low-premium plans in the Exchange

Question#5. What rules (if any) should the State consider as part of establishing the open enrollment period?

Exchanges will have open enrollment periods for private plans and states will have to simplify and streamline the process of renewing coverage, as well as the initial application process to help people stay insured, and they'll need to make sure that it is easy for people to move between private coverage and Medicaid as their circumstances change. For example, an insurance company could set the start of its policy year for January 1 and allow an annual open enrollment period from December 1 to December 31 each year. A different company could allow quarterly open enrollment periods. Both situations assume that there are no State laws that set the timing and duration of open enrollment periods.

Open enrollment periods will be the most effective if there is a standard time (the same months each year) and at least 90 days to sign up or change policies.

Exchange must be able to enroll individuals as well as small employer in a user friendly manner. For this certain rules have to be considered by the state.

- Implement a web portal where consumers and businesses can view coverage options, with benefits and costs presented in a standardized format
- Operate a toll-free hotline for consumer assistance
- Be able to screen eligibility for, and enroll people in, Medicaid, the Children's Health Insurance Program (CHIP), and other public programs
- Establish "navigators"—individuals or entities that help consumers and employers learn about, and enroll in, coverage options
- Inform consumers of available plan and benefits covered.

Question#6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

The federal government will create standards to help states establish and maintain a reinsurance program by January 1, 2014. Health insurance providers will make payments to a reinsurance "entity." This

entity will then make payments to health insurance providers that cover high risk patients. State high-risk insurance pools will either be eliminated or modified in order to carry out this reinsurance program.

Sec. 1343 requires every state to charge a fee for health insurance providers if the risk of the individuals enrolled in these plans is less than average for the year. States must pay health insurance providers if the risk of enrollees is greater than average. Self-insured health plans are excluded.

State-Based Reinsurance Programs and Risk Provisions Supporting the Exchange Transitional Reinsurance Program for Individual Markets

Section 1341 of the Act mandates establishment of state-based reinsurance programs no later than January 1, 2014, to facilitate initial operation of the Exchange. The reinsurance programs will be based on standards promulgated by the Secretary of Health and Human Services (the "Secretary"), in consultation with the National Association of Insurance Commissioners. Under the programs, health insurers and third-party administrators on behalf of group health plans will be required to make payments to a not-for-profit reinsurance entity established by or contracted with the state.

Establishment of Risk Corridors for Plans

Section 1342 of the Act provides that the target allowable costs for a qualified health plan in the individual and small group market should equal the total insurance premiums. It requires the Secretary to establish and administer a program of risk corridors for the first three calendar years of the Exchange to address any deviations from the target allowable costs. Under the program, a qualified health plan offered in the individual or small group market must participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. If a plan's costs are higher than 103% of total premiums, the Secretary will be required to make payments to the plan to address the excess.

Risk Adjustment

Section 1343 of the Act protects against anti-selection based on health status by requiring states to impose charges on health plans in individual or small group markets consisting of insureds with lower than average actuarial risks, and making payments to plans consisting of insureds with higher than average actuarial risks. The Secretary is charged with developing, in consultation with states, criteria for carrying out these risk adjustment activities.

Question#7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

Health insurance brokers' generally play an influential and critical role in the distribution of health insurance across the country. Brokers serve as the de facto benefits office for many small businesses, providing firms with a range of services, including assistance with health insurance, disability coverage, life insurance, and other ancillary lines of coverage. Business owners rely on brokers to sort through their health insurance options, provide health plan recommendations at the time of renewal, and serve as their agents throughout the year in dealings with insurers. As noted above, small group brokers in many markets often use

intermediaries to provide back-office support before, during, and after enrollment. The intermediaries perform administrative functions that are typically handled by large employers' human resources office and/or by the health carriers.

Brokers play a prominent and important role among small employers. They often have longstanding and trusting relationships with their clients, and they provide information at the ground level about health insurance options. Determining how best to leverage the expertise of health insurance brokers and to make an effort to include them in the outreach and enrollment program will prove invaluable to exchange administrators. Brokers and Agent in addition to existing role that they are performing in the current system can also act as Navigators and perform the following functions:

- conduct education campaigns to raise awareness of the qualified health plans
- distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under and cost-sharing reductions
- facilitate enrollment in qualified health plans
- provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the law, or any other appropriate State agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

2.4 Structure of the Exchange Marketplace

Question#1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

Key purpose of Health Insurance Exchange is providing a common marketplace to bring together buyers as well as seller for healthcare insurance. Though it appears a simple proposition state of Illinois must give consideration to following criteria before taking a decision to establish an exchange:

- **Cost:** Under PPACA States are eligible for grants to setup exchanges. These grants can be renewed by federal government based on states progress in establishing an exchange but there will be an ongoing maintenance cost associated with each exchange. Though the act permits state to charge assessments or user fees to participating health insurance issuers to support their operations; there will be pressure to keep this cost as low as possible to make the exchange successful.
- **Administration:** Along with the cost factor state of Illinois also needs to give due consideration to administration of exchange. State of Illinois must assure that exchange is accessible to potential members and proper marketing and education does happen to make sure information and benefits do reach the intended audiences. State of Illinois also needs to make sure that qualified plans in exchange are affordable, reach intended population and at the same time are financially viable for all the insurers participating in the exchange.

- Another aspect which state of Illinois needs to consider is eligibility for programs like Medicaid and SCHIP. Exchange will have to determine the eligibility of new uninsured population and coordinate their enrollment in these programs. Also exchange will have to take care of subsidy eligibility. This bring with it added accounting and increased investigation and audits from federal government.
- Thus establishing and having business operations of an exchange at minimum will involve complexities of management and administration of infrastructure along with general management and financial liabilities.
- Merging the small-group and individual insurance markets within a state will allow one exchange to serve both individuals and small businesses, substantially increasing its potential enrollment volume. Greater enrollment also will promote more robust competition among insurers within an exchange. Merging the individual and small-group markets may increase prices for non-grandfathered plans in either the individual or small-group market to some extent.
- Thus, it is advisable to have a single exchange in a state for both individual and small employer combined in one, but the state of Illinois should be aware that the essential functions of these two markets are different and state of Illinois should consider different exchanges only if there is substantial market for both which is necessary for exchange to be financially sustainable in the long run.

- State can explore options of tools/platforms and consortiums which will aid state in controlling the cost and bring on table all the require stakeholders for effective and efficient governance. Readymade tools/platforms can bring in fresh idea like creation of union of small employer in an exchange to provide a better bargaining power to small businesses.

Question#2. If there will be separate markets and separate exchanges, how large must the pools within these markets be to ensure stable premiums for both?

- Operating separate Exchanges for individuals and small groups would allow states to set different rules for each market's Exchange, which may have added benefits, costs, and complications.

- It would also have the implications discussed below of maintaining separate risk pools for the two groups, as federal health care reform mandates that if a state has multiple Exchanges, then the state must serve different markets. On the other hand, one exchange for both markets would mean that all plans would have to follow the same rules and meet the same regulations, which may as well have added benefits, costs, and complications.

- Maintaining separate risk pools for individuals and small employer group members would result in insurers rating premiums separately for each of the two groups; that is, the adjusted community rating rules in federal health care reform would still apply, but the two groups would be rated separately.

- In general, a strong and stable market relies on a large, variable risk pool to reduce destabilization by large claims or a small number of high users (people with very poor health status). Therefore, in order for the Exchange to be successful with separate risk pools, each pool must be large enough to be stable.

- The primary concern is the success of a market in the Exchange is the individual market. Beginning in 2014, the existing individual market products will be converted to adjusted community rating, required to issue federally approved benefit designs. The combination of these factors will likely result in premium increases for people in the current individual market. If so, there is a risk people will drop coverage, and the individuals who remain will be higher utilizers than the individuals who drop coverage. This could lead to instability in the market. Therefore, a crucial policy issue is whether and how to ensure a sufficiently large pool within the market to stabilize premiums.

- One approach is to merge the individual and small group markets. Another approach is to eliminate the external individual market so that all individual insurance is sold through the Exchange. Yet another approach is to promote take-up among health individuals in the Exchange to expand the pool.

- In order to prevent the Exchange from becoming a high-risk pool, it would be critical to design the best structure to rating, pools, and take-up, especially if the individual and small group risk pools are separate.

- Pooling individuals and small employer group members into one pool would still present a need to promote take-up, but the pool would be larger. In this case, the profiles of individuals and small employer group members must be monitored to ensure that the two groups are not so drastically different that they cause a single pool to be more unstable than two separate pools.

Question#3. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

Start with manageable levels of employer participation. State of Illinois may want to consider limiting eligibility to employers with up to 50 employees initially and not extending Exchanges to the large employer market in order to:

- *Help ensure success by starting with more manageable levels of participation.* Only after State Exchanges function well at serving the 1 to 50 market segments should consideration be given to expansion. Offering Exchanges in the employer market adds levels of complexity (e.g., employer contributions, etc.) that need to be managed carefully to ensure high service levels. For example, the Massachusetts Connector started with a pilot for small employers, which was expanded this year. They had Contributory Plan for small employers with less than 50 employees.
- *Limit adverse selection that would cause higher premiums for individuals and small employers* if larger employers – who have greater ability to self-fund – disproportionately seek coverage through the Exchange when they have higher cost employees.
- *Target those most in need* of additional access to insurance. Exchanges will be most beneficial to individuals and smaller groups because historically they have faced challenges with access to affordable health care coverage

A 2000 report funded by the Robert Wood Foundation said, “The idea of having small employers collectively purchase health insurance has intuitive appeal, and it has been supported by thoughtful health analysts and politicians with widely different philosophical perspectives.” The success of Health Pass supports this idea as the median size of the group was 5 full time employees.

We believe that state should start with the small businesses with employees between 2 to 50 and should enroll bigger (employee between 51 to 500) business in a phased manner so that eligibility determination and compliance check is done properly for each employer.

Question#4. Should Illinois consider setting any conditions for employer participation in the shop Exchange (*e.g*. minimum percent of employees participating, minimum employer contribution)?

The summary presented in question (If there will be separate markets and separate exchanges, how large must the pools within these markets be to ensure stable premiums for both) can be applied to the “small employer” and setting conditions for employer participation. Decisions like whether or not to limit the definition of “small employer” to 2-50 people, State needs to decide how different the profiles and needs are of employees in businesses with 2-50 people than the profiles and needs of employees in businesses with 51-100 people. These differences will need to be weighed with the potential benefits and complications of combining the two groups.

Having said all this we believe putting condition on participation on any consumer or small employer will discourage the group from participation in exchange which can be detrimental for exchange success. So on the other hand we suggest state should try and accommodate (in a phased manner) as many consumers as possible to have exchange a successful and self-sustaining. .

Question#5. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

- Key Factor for success of exchange is it far and wide reach. If more people participate in exchange more sustainable will it be.
- So state should definitely permit large groups in exchange but in a phased manner.
- This will help achieve following things for the state
    - Financial stability for exchange and for state
    - Achieve ACA goal of coat containment ; since more is the participation in exchange bigger will be the risk pool which will reduce and control the premium prices and hence healthcare cost
    - More people in the state will be insured and state can track noncompliance easily.
    - State will be able to achieve better standardization and control of state as well as federal mandate benefits offered through exchange.

Question#6. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

States have different options to consider when establishing the Exchange. ACA allows State to join together and form regional or multi state exchanges. States could describe any plans they have to form or join a regional exchange in the exchange planning grants along with how they plan to make sure they work well for consumers. Regarding regional exchanges, states and advocates should consider the following:

- PPACA has introduced nationwide protections in insurance markets. However while joining the multi-state exchange state should consider that some states have very consumer friendly climates, with many protections to make sure that insurers play fairly in the market, while others exercise little oversight of insurer behavior. Regional exchanges may work well for smaller states, creating a larger market, broader risk pools, and lower administrative costs. However, states must ensure that potential partner states share their goals for consumer protections before joining a regional exchange

- The politics of your state may have a big impact on whether and with which partner states your state will form or join a regional exchange. Additionally, political challenges that may result from more than one state sharing authority over an exchange should also be considered.

Some possible advantages to joining a regional exchange:

- Capitalizes on economies of scale potentially reducing relative administrative costs.
- Procurement of IT and other resources might bring efficiencies and/or economies of scale
- Makes use of work already done by other states.
- Creates large risk pools attractive to insurers and important for a successful exchange.
- States can share best practices and learn what works

Some possible disadvantages to joining a regional exchange:

- States have different demographics and cultures.
- May be difficult to coordinate across states, particularly given on-going activities
- Each state has its own procurement rules which may make collaboration difficult
- States may have different goals that impact ability to collaborate on specific issues

To conclude State can have different geographical regional exchanges but the basic IT infrastructure should remain the same. State should also consider the cost for admiration for multiple exchanges.

Multi-state regional exchange may run into legal issues around regulatory compliance requirements across different states and hence could lead to confusions and biases. It may not be flexible towards a particular state based on state characteristics and hence may not be attractive option for consumers. State of Illinois should look at starting as a state-level exchange and then take incremental approach to move towards regional exchange depending on criteria's favorable across stakeholder community

2.5 Self-Sustaining Financing for the Exchange

Question#1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

- Past experiences of exchanges show that for it to become self-sustainable is not an achievable goal within 2-3 yrs. of timeframe. This depends on various factors associated with state enrollee-base, market captured by the exchange, medical loss ratio of the exchange and the administrative expense the exchange needs to bear.
- The exchange should upfront start planning the funds and develop a business case for funds identification and planning. Few factors to be considered in planning and fund raising post grants could be as follows.
- **Assessments on insurers** – Exchange can generate funds from assessments on insurers which can indirectly be collected from enrollees by the insurers. Exchange can also charge the assessments to the enrollees or small employers directly through premiums.
- **User Fees -** This could be per member per month kind of a fee structure to distribute the administrative costs of enrolling members and collecting premiums through exchange on behalf of the insurer. Since exchange will relieve insurers from major administrative overheads, it makes sense for insurers as well to pay subsidized charges.
- **Taxes from insurers and providers and individual Tax credits –** Exchange may also raise funds through the taxes to be collected from all the insurers and providers. Exchanges can also use 95% of the tax credits that would have been available to the enrollees.
- **Funding from State of IL Medicaid –** Exchange may charge state Medicaid agencies to process the Medicaid enrollments.
- **Funding from relevant advertisements of preventive care or educational programs -** The advertisements could be released through different forms of media such as radio, television, internet or print.
- Exchange can also look at cost optimization and cutting strategies to make maximum usage of the available funds.
    - **Administrative costs reduction -** The prior exchanges show that the administrative expenses themselves range in millions per year. Automating many administrative features using technology can greatly help in cost savings. Contracting with a vendor that provides all operational and administrative services and infrastructure for functions such as customer relationship management, billing, premium payments, payment reconciliations, handling commissions etc all under one umbrella may reduce the contracting burdens and the automation will also reduce manual errors.

- Administrative burden however also depends on the size of enrollee base and hence in case of small employers as mentioned earlier, the employee base should very less (around 50+) in order to control costs.
- **Increase enrollee base through Premium reduction by participating insurers –** Since exchange should provide the insurers access to larger market, it makes sense for insurers to cut-down on premiums which in turn can help in increasing market capture further.
- **Subsidize and standardize brokerage commissions -** Exchanges should limit brokerage commissions to a flat per member per-month dollar amount regardless of insurer (the way Utah Health Exchange has done).

- All the above mentioned avenues do not put any additional burden on the state for functioning of the exchange and at the same time do not cost a lot to consumer participating in exchange.

Question#2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

Considering the above financing options (response to previous question) given such as the **User fees**, **Taxes from insurers and providers and individual Tax credits**, **Assessments on insurers**, etc. there will not be any burden on the State of IL to incur additional funds to run the exchange successfully. The members or the target population will bear minimal yoke of user fees and the rest of the burden will be shared by insurers through assessments, taxes and user fees.

Question#3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?

- The PPACA also allows additional benefits to be offered apart from the 'minimum essential benefit' and the funding source for these benefits will be additional charges in the premium based on the richness of the additional coverage provided.
- State of IL will need to continue using the current funding sources for the state benefit mandates if they decide to maintain all of it mandated benefits.
- For those benefits that are not part of essential benefits as defined by the Federal reform, State of IL could consider offering an option for exchange purchasers that state mandated benefits be given as supplemental or "rider" coverage to the essential packages for qualified health plans.
- The state government could also reconsider some of its benefit mandates on insurers and plans in the exchange.

2.6 Eligibility Determination

Question#1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

To ensure the success of Exchange operations it is critical to ensure the implementation of the following:

- Develop a user friendly, coordinated system to sign up for the health insurance plan that they opt for through the exchange.
- Develop Integrated Eligibility systems:
    - Eligibility determinations consist of data-matching to ensure an applicant is not enrolled in an alternative commercial insurance or has access to employer sponsored insurance. Medicaid, SCHIP and the Exchange must use a secure electronic interface capable of determining individual's eligibility for coverage. If Medicaid/CHIP finds members ineligible for those programs, provisions must be made to refer them to the Exchange to be reviewed for coverage and possible state-specific subsidy eligibility. Need to develop an integrated system for Medicaid and CHPlus eligibility and enrollment with the exchange and effectuate data matching with Federal and State systems
- Develop a system that will coordinate enrollment and eligibility determination and re-determination for participation in state health subsidy programs and ensure that Medicaid- or CHPlus-eligible individuals who apply for coverage through the exchange are enrolled in the applicable public insurance program.
- Upgrade existing eligibility system infrastructure for Medicaid Systems and CHPlus systems
- Efficient data exchange between federal and state health programs is very important
- Develop an application that can span multiple sources of coverage and health insurance assistance

Develop a centralized state level eligibility database as this will help conduct eligibility reviews in an efficient manner. This collection of eligibility rules in a single location will also allow transparency in eligibility rules across the State.

Question#2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

- Employer sponsored insurance coverage is rare among low –income members. These members are more susceptible to unemployment thus making them move between private and public insurance coverage.
- State of IL could consider providing a possible overlap between the exchange offered qualified health plans and the public plans which could also include the covered providers.

- State of IL could also consider the extent to which these members (who move across Medicaid, CHIP and qualified health plans) are able to continue with their coverage and providers while proposing the eligibility criteria for the exchange offered qualified health plans. The state could also establish ways to improve continuity if a particular threshold percentage of members are able to do so.
- Enabling PHR on the exchange would ensure that data is available among providers. So even if members move across plans, this facility will promote effective data availability with PCP's.

Question#3. What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

- Payment Reforms will shift a great amount of cost accountability to the provider thus increasing the quality of care coordination.
- Payment reforms are also a platform to reward providers financially for providing high quality healthcare while using the available resources efficiently.
- Shifting from a traditional 'Fee for service' model to 'Pay for performance' model across Medicaid, Medicare, etc. will ensure high quality of care irrespective of the individual's plan.
- Providers are one of the key stakeholders in the Exchanges. Incentives could be established for providers based on their performance, compliance, certification in the state and/or network etc

Question#4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

- Yes, State of IL can establish a 'Basic Health Plan' to provide affordable coverage option for families between 133% and 200% of the federal poverty level.
- Under section 1331 of PPACA, the state may operate a "Basic Health Plan" for individuals between 133% and 200% of the federal poverty level and use 95% of the tax credits that would have been available to these individuals for Exchange coverage to operate the "Basic Health Plan". This is a good option to establish a Basic Health Plan.
- State of IL would receive a federal payment of 95 percent of what would otherwise have been provided for premium tax credits and cost-sharing reduction payments. The finance aspect will be taken care by the tax credits. It is important to note that it would add to administrative cost of such plan and the 'Basic Health Plan' also discourages receiving premium subsidies by individuals.
- States that offer the Basic Health Plan must ensure that the benefits are at least equivalent to the essential health benefits and premiums are not higher than those in the Exchanges.

- The uniform benefit package (defined The DHHS Secretary), also referred to as the essential health benefits, will include at least the following general services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health benefits and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.
- All insurers will be governed to provide the above mentioned coverage as part of group or individual insurance. If a member moves anytime from group to individual coverage (or vice versa), his plan would ensure that he has these basic coverage's thus avoiding discontinuity of coverage.

Another option would be to start the Basic Health Plan as a part of Medicaid program

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